Friday Morning Collaborative Webinar

State Oversight and Quality in Managed Long-Term Services and Supports

December 6, 2013

National Council on Aging

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Friday Morning Collaborative

- American Association on Health and Disability
- American Association of People with Disabilities
- AARP
- Alliance for Retired Americans
- American Federation of State, County and Municipal Employees (AFSCME)
- American Network of Community Options and Resources
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer's Association
- Bazelon Center for Mental Health Law
- Center for Medicare Advocacy
- Community Catalyst
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Health and Disability Advocates
- Leading Age
- Lutheran Services in America
- National Association of Area Agencies on Aging
- National Association of Council on Developmental Disabilities
- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Domestic Workers Alliance and Caring Across Generations
- National Health Law Program
- National PACE Association
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- United Spinal Association
- VNAA –Visiting Nurse Associations of America

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University of San Francisco, California

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Questions and Comments

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Webinar Overview

- Introduction
  - Joe Caldwell (National Council on Aging)
- Speakers:
  - Patti Killingsworth

    Assistant Commissioner, Chief of Long Term Services & Support, Bureau of TennCare
  - Jami Snyder

    Centene Corporation; former Operations Administrator, Acute and Long Term Care, Arizona Health Care Cost Containment System
  - Thomas Shumard

    Health Insurance Specialist, Division of Quality, Evaluation and Health Outcomes, Centers for Medicare and Medicaid Services
- Questions and Answers (20 – 30 minutes)

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TennCare

CHOICES

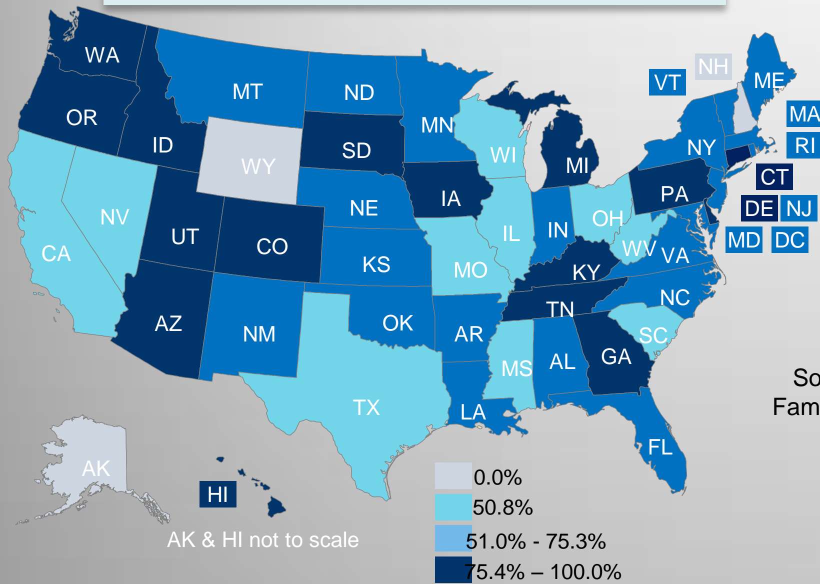
in Long-Term Services and Supports

State Oversight and Quality in Managed Long-Term Services and Supports

TennCare

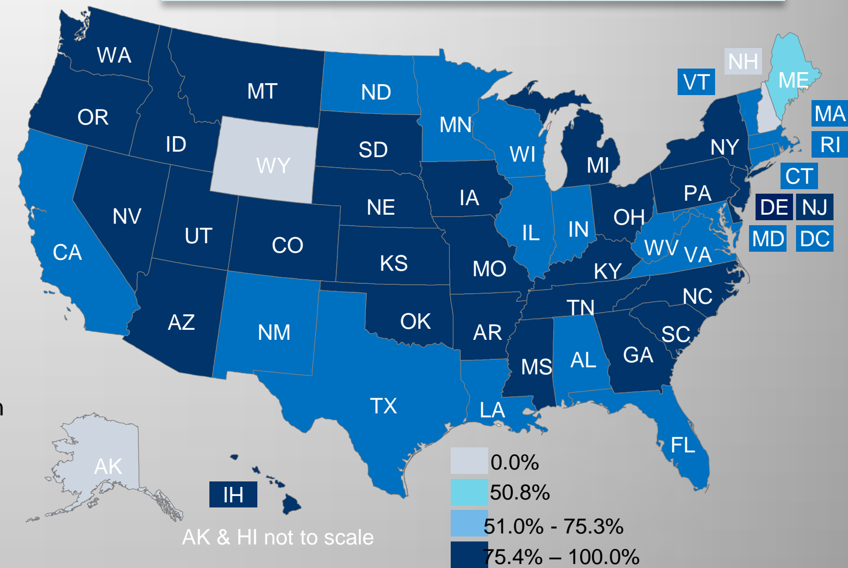
Managed Care Expansion: A National Trend

Penetration of Medicaid Managed Care, 2004

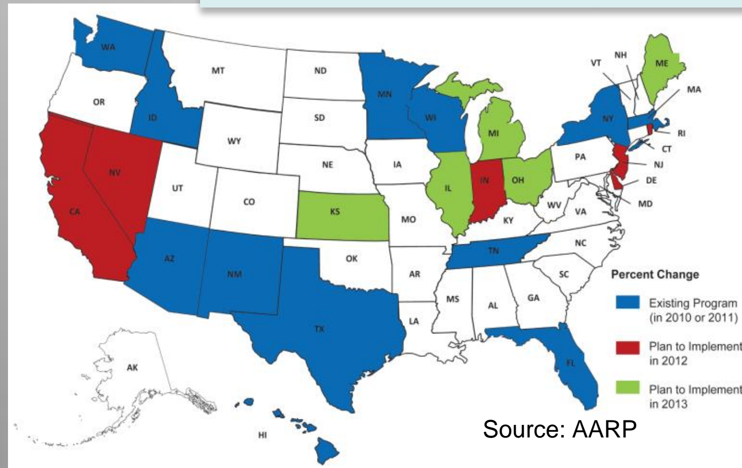


Source: Kaiser Family Foundation

Penetration of Medicaid Managed Care, 2011



States with Medicaid Managed LTSS



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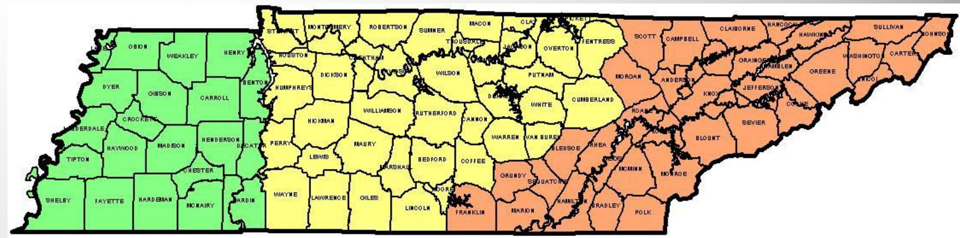
TennCare Overview



- Tennessee's Medicaid **Agency**
- Tennessee's Medicaid **Program**

- Managed care demonstration implemented in 1994
- Operates under the authority of an 1115 waiver
- Uses managed care to cover persons otherwise not eligible for Medicaid
- *Entire* Medicaid population (1.2 million) is in managed care
- Medical, behavioral and (since 2010) LTSS for E/PD administered by two NCQA accredited "At-Risk" Managed Care Organizations (MCOs) located in each region of the state (*mandatory* enrollment in managed care)
- ICF/IID and 1915(c) ID waivers carved out; populations carved in
- Statewide back-up plan (TennCare Select) manages care for certain special populations (e.g., children receiving SSI, children in State custody, persons enrolled in ID waiver programs) via an ASO (i.e., modified risk) arrangement
- Prescription drugs administered by statewide Pharmacy Benefits Manager
- Dental Services (< 21) administered by statewide Dental Benefits Manager
- MLTSS program is called "CHOICES"

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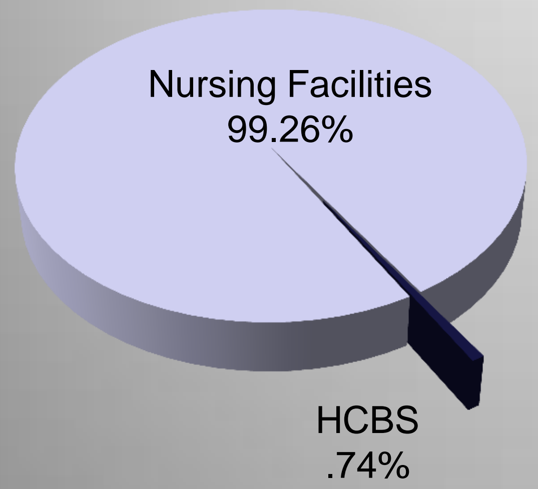
Why Managed Care?

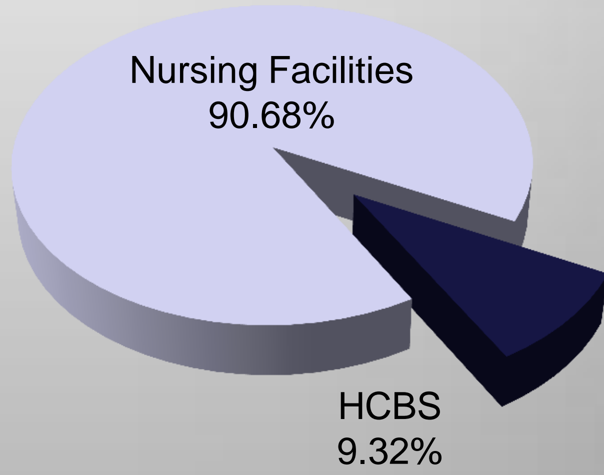
The LTSS System in Tennessee *before*...

- **Fragmented**—carved out of managed care program
- **Limited options and choices**
- **Heavily institutional**; dependent on new $ to expand HCBS



FY 1999

< 1% HCBS



FY 2009

~ 10% HCBS

Restructuring the LTSS System: Key Objectives

- **Reorganize** – Decrease fragmentation and improve coordination of care.
- **Refocus –** Increase options for those who need LTSS and their families, expanding access to HCBS so that more people can receive care in their homes and communities.
- **Rebalance** – Serve more people using existing LTSS funds.

Setting the Stage

- Announced by the Governor in his *State of the State*
- Began as a legislative initiative: *The Long-Term Care Community Choices Act of 2008; a*vailable at http://www.hcbs.org/files/142/7086/tn_ltc_community_choices_act.pdf
- Key sponsors – members of a bi-partisan Long-Term Care Study Committee
- Passed unanimously by the General Assembly in an election year without a single "no" vote *ever*—in any committee, sub-committee, or on the floor
- Broad stakeholder engagement
  - Focus on program objectives
    - Improved coordination and quality of care: *Right care, right place, right time*
    - Expanding access to cost-effective HCBS - *"There's no place like home."*
    - More efficient use of LTSS funding – serving more people with existing $
  - Efforts to understand and address key areas of stakeholder concern and preserve core values

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Key Design of MLTSS

- Integrated nursing facility (NF) services and HCBS for seniors and adults with physical disabilities into existing managed care program (roughly $1 billion) via an 1115 waiver; ICF/IID and ID waiver services carved out
- Amended contracts with existing MCOs selected via competitive bid process
- Blended capitation payment for physical, behavioral and LTSS
- MCOs at full risk for all services, including NF (not time-limited)
- Enrollment target for HCBS supports controlled growth while developing sufficient community infrastructure to provide care (persons transitioning from a NF and certain persons at risk of NF placement are exempt)
- Cost and utilization managed via individual benefit limits, levels of care (LOC), and individual cost neutrality cap (for those who meet NF LOC)
- Freedom of choice of NF versus HCBS (must be safe and cost neutral)
- Comprehensive person-centered care coordination provided by MCOs
- Consumer directed options for core HCBS using an employer authority model
- Electronic Visit Verification system helps ensure fiscal accountability and provides immediate notification/resolution of potential gaps in care

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State Capacity to Administer (i.e., "Manage") Managed Care

- **State Medicaid Agency role and responsibilities**
- **Detailed program design and contract requirements to ensure member choice, continuity of care and health plan readiness,** including aligned financial incentives and enforcement mechanisms
- **Comprehensive readiness review strategy**
- **Ongoing monitoring and quality oversight**

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State Medicaid Agency

- **Organized around the delivery of managed care**
  - --Managed Care Operations
  - --Provider Networks/Services
  - --Quality Oversight
  - --LTSS (Audit & Compliance, Quality & Administration) "integrated" into the SMA
  - --Member Services
  - --Finance and Budget (Health Care Informatics)

State Medicaid Agency

Health Care Finance and Administration Staffing Structure

Deputy Commissioner/ Medicaid Director

Chief of Staff/Deputy Director

Managed Care

Quality Oversight (21 staff members)
- Director and Assistant Director (2)
- Administrative (4)
- Programmatic (6)
- Statistical (1)
- Nursing (8)

MCO Compliance (14 staff members)
- Director (1)
- Administrative (1)
- BH Compliance and Operations (4)
- MCO Compliance (8)

Pharmacy (7 staff members)
- Director (1)
- Assoc. Directors (2) – Clinical & Ops
- Data Analyst (1)
- Call Center Operators (3)

Program Integrity (21 staff members)
- Director (1)
- Administrative Support (1)
- Project Manager RAC (1)
- Investigations (8)
- Analytics (10)

Provider Services (25 staff members)
- Director (1)
- Administrative staff (2)
- Supervisory staff (4)
- Database Mgr/Programmer staff (2)
- Program staff (14)
- Clerical staff (2)

Dental (1 staff member)
- Director (1)

Long Term Services & Support

Administrative (4 staff members)
- Chief and Assistant Chief (2)
- Administrative Support (2)

Operations (38 staff members)
- Deputy (1)
- Clinical Program Director (1)
- Operations Director (1)
- Call center and training director (1)
- Managers (5) – incl. 2 nurse mgrs
- Nurses (10)
- Support staff (5)
- Program specialists (6)
- Call center staff (6)
- Appeals staff (2)

Audit and Compliance (16 staff members)
- Deputy (1)
- Assistant Deputy (1)
- Director (1)
- Assistant Directors (4)
- Monitors and Auditors (9)

Audit and Compliance (16 staff members)
- Deputy (1)
- Assistant Deputy (1)
- Program Directors (3)
- Data and housing staff (3)

Member Services

Medical Appeals (95 staff members)
- Director (1)
- Attorneys (9)
- Legal Assistants (36)
- Managed Care Specialists (30)
- Nurses (7)
- Supervisors (7)
- Clerks (5)

Eligibility (10 staff members)
- Eligibility specialists (8)
- Notice specialists (2)

Fiscal

- Administrative (2 staff members)
- Budget (2 staff members)
- Payments/Accounting (22 staff members)
- Business Sector Analysis (14 staff members)
- Contracts (3 staff members)
- Health Care Informatics (11 staff members)
- Third Party Liability (1 staff member)

Information Systems

- Operation/Eligibility (30 staff members)
- Claims/Encounter Ops (10 staff members)
- Development/EDI (10 staff members)
- Technology (10 staff members)

Additional Staffing Information:

Policy – 6 staff members
Project Management Office – 6 staff members
Internal Audit - 12 staff members
Operations/Legislative – 13 staff members
Communications – 3 staff members
Office of General Council – 23 staff members

February 2013

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Interaction with Other State Agencies

Department of Human Services (Social Services)
- Eligibility
- Enrollment

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Office of the Inspector General (OIG)
- Enrollee fraud

Commerce and Insurance
- Licensure
- Financial reserves
- Provider appeals (independent review process)
- Provider contracts
- Prompt pay
- Claims payment accuracy
- In-depth reviews of specific issues

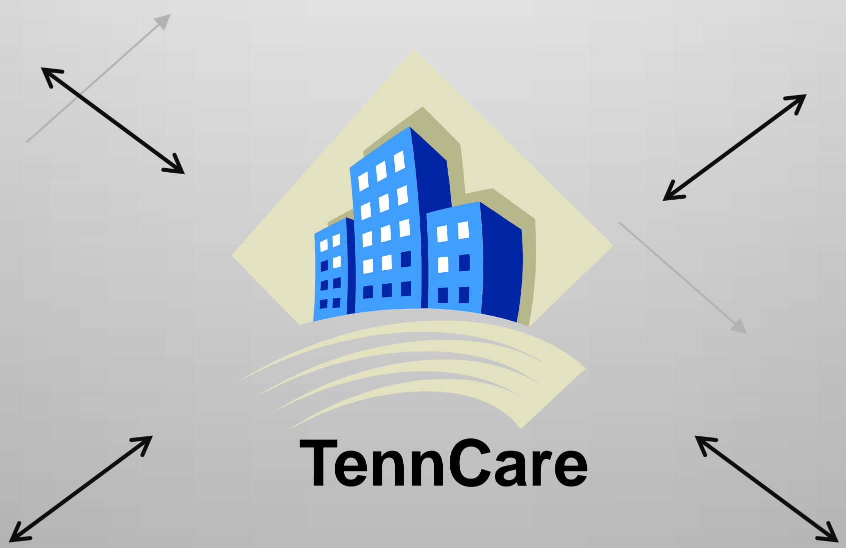
Intellectual Disabilities
- 1915c waiver benefit administration

TN Bureau of Investigation (TBI)
- Provider fraud

Interaction with Other State Agencies

Children's Services
- Targeted case management
- Delivery system

Health
- EPSDT outreach
- Dental sealants
- Home visits
- Presumptive eligibility



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Mental Health
- Evolution of this relationship through carve-out and carve-in

Corrections
- Data sharing
- Future relationship if Medicaid expansion

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State Medicaid Agency

- **Contractors** include actuary, EQRO, fiscal employer agent for consumer direction, legal consulting services, member services call center, advocacy/outreach call center; medical appeals vendor, MMIS vendor, SPOE, TPL vendor, member satisfaction survey
- **Partners/stakeholders** include contractors, MCOs, providers/organizations, members/advocacy groups, legislators, and taxpayers
- **Integrally involved in day-to-day program management and oversight/monitoring**

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Detailed program design and contract requirements

--Developed in consultation with partners/stakeholders
--Reviewed and amended at least every 6 months
--Aligned financial incentives and enforcement mechanisms, including CAPs liquidated damages, and capitation payment withholds

- **CRA available at:** http://www.tn.gov/tenncare/forms/middletnmco.pdf

- **Contracting considerations for members**

  --Freedom of choice (settings and providers)
  --Continuity of care
  --Care coordination (model, processes, timelines, tools and staffing)
  --Consumer direction
  --Education/outreach

- **Contracting considerations for providers**

  --Any willing qualified provider
  --Authorizations
  --Reimbursement
  --Prompt payment and claims payment accuracy
  --Training and technical assistance

Comprehensive Readiness Review Strategy

- Review of key desk deliverables
- Onsite review of critical processes and operating functions
  --Care coordination
  --Service authorization
  --Training
  --Care coordinator ride-alongs
  --Demonstration of critical MCO systems – case management, tracking, service authorizations, claims
- Systems testing – end-to-end testing of eligibility, enrollment and encounters
- Other verification and validation activities
  --Key milestone deliverables: provider networks and service authorizations

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Ongoing Monitoring and Quality Oversight

- Uniform measures of system performance
- Detailed reporting requirements
  - Purposes:
    - To assure compliance by contractors to contract standards
    - To provide actionable information for Program Management
    - To provide information for Strategic Planning
  - Standardized templates
  - Deliverable tracking system
  - Testing/validation
  - Analysis/reporting -----→ ACTION

TennCare

Ongoing Monitoring and Quality Oversight

- Ongoing audit and monitoring processes
  - Critical Incidents, New Member, Referrals, Provider Credentialing, Other select items
- Measures to immediately detect and resolve problems, including gaps in care – Electronic Visit Verification
- Independent review (External Quality Review Organization, Tennessee Department of Commerce and Insurance)
- Key focus on member perceptions of quality
  --QOL/Member satisfaction survey
  --Consumer advisory groups
- Advocacy for members across MLTSS system

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Advanced Data Analytics

Payer Name (TennCare/ Commercial) | Provider Name | Provider Code | Report Date: July 2013

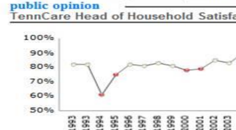
[1. Perinatal] C. Episode cost details

6 Episode cost breakdown by care category (risk adj.)

Total episodes included: 233 — Your performance — Provider base average

Care category	# of episodes with claims in care category	% of episodes with claims in care category	Average risk adj. cost per episode when care category utilized ($)
Outpatient professional	195	84% / 82%	120 / 120
Pharmacy	11	5% / 5%	50 / 50
Emergency department	90	39% / 30%	235 / 230
Outpatient lab	220	96% / 84%	190 / 200
Outpatient radiology/ procedures	215	94% / 88%	320 / 330
Inpatient	220	96%	

TennCare managed care operations

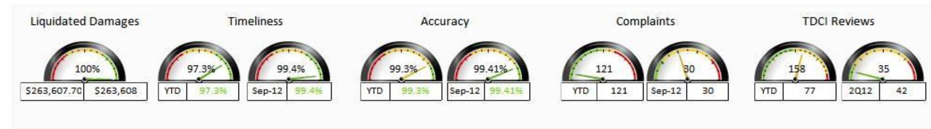


Key Figures | 11.07.2012

FY 2013 Liquidated Damages

Region	CAP	Assessed	Recouped	%
East		$38,200	$38,200	100%
		$15,100	$15,100	100%
Middle		$20,700	$20,700	100%
		$80,500	$80,500	100%
West		$7,500	$7,500	100%
		$14,200	$14,200	100%
State-Wide	ASO	Assessed	Recouped	%
		$6,500	$6,500	100%
		$52,700	$52,700	100%
		$19,500	$19,500	100%
	State	Assessed	Recouped	%
		$0	$0	100%
		$8,708	$8,708	100%
		$0	$0	na

Overall



TennCare quality oversight 2011

Key Figures | 10.12.2011

national position

Star Ratings [NCQA]

Tennessee: 80.9% [3 Stars]

	2010	2011
UHE	80.4%	81.6%
BCE	83.1%	80.9%
UHM	81.6%	82.9%
AGM	82.9%	83.1%
UHW	78.7%	79.9%
BCW	81.4%	79.8%
TCS	78.0%	78.2%

incentives

Quality of Care & Services

HEDIS Effectiveness of Care

Measure: Breast Cancer Screening [BC

	2010	2011	change
UHE	42.99%	41.01%	-1.98%
BCE	49.06%	48.78%	-0.28%
UHM	42.49%	44.21%	1.72%
AGM	25.22%	42.71%	17.49%
UHW	na	35.31%	na
BCW	39.54%	45.19%	5.65%
TCS	na	na	na

public opinion

TennCare Head of Household Satisfa

Survey: 4.0H Adult Version

Measure: Shared Decision-Making

	result(x)
UHE	60.17%
BCE	53.84%
UHM	56.44%
AGM	54.07%
UHW	52.33%
BCW	57.31%
TCS	59.52%

2010 National Medicaid: na

2011 State Medicaid: 56.24%

Top Three: UHE 60.17%, TCS 59.52%, BCW 57.31%

Bottom Three: AGM 54.07%, BCE 53.84%, UHW 52.33%

Mission

Working together to continuously improve the health and satisfaction of TennCare enrollees.

Sources

- Qsource Comparative Analysis [August 2011]
- National Committee for Quality Assurance [NCQA]
- Agency for Healthcare Research and Quality [AHRQ]
- Contractor Risk Agreement [CRA]
- UT Center for Business and Economics Research Survey

Tools

- HEDIS measures [NCQA]
- CAHPS Surveys & Tools [AHRQ]
- Minimum Effect Size [Dr. Long, MMIS 2008]

TennCare pharmacy

key figures data as of 08.16.2012

eligibility — members: 1,071,339; 1,073,169; 1,068,391 — users: 382,012; 386,251; 415,305 — patient ratio: 357:1000; 359:1000

top 5 prescriptions

utilization — prescriptions: 12.8M; 13M; 1,069,044; 1,080,221 — prescription limits — overrides

most expensive

spending — cost before rebates: $753M; $824M; $62,772,909; $68,646,072; $59; $64 — rebates by quarter: $381M; $393M — cost after rebates: $372M; $431M; $31,031,033; $35,932,783

call center — call volume: 442,359; 432,889 — wait time — handle time — abandonment: 3,720; 3,190

Provider Code | Report Date: July 2013

...lization details

Group B strep screening rate

Chlamydia screening rate

Quality metrics not linked to gain sharing

Gestational diabetes screening rate

Asymptomatic bacteriuria screening rate

Hepatitis B screening rate

Utilization metrics not linked to gain sharing

C-Section rate

Ultrasound rate

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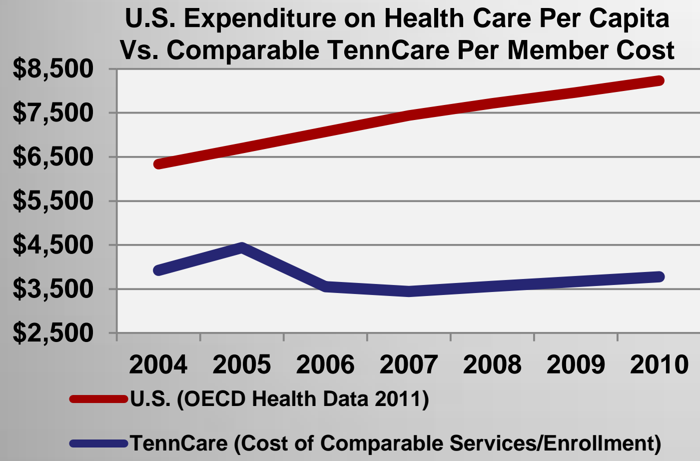
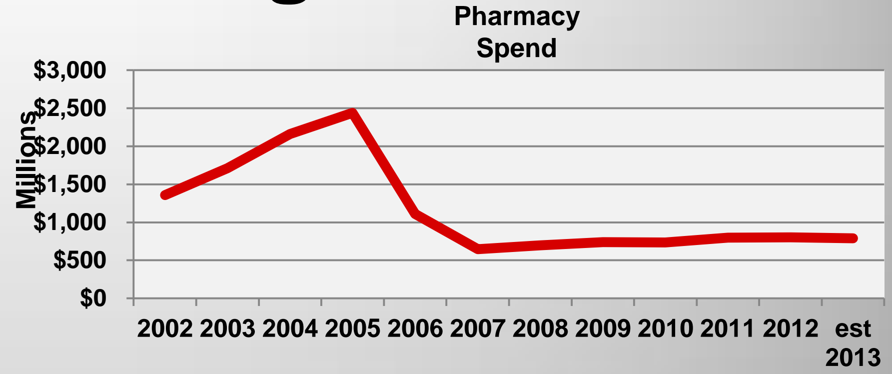
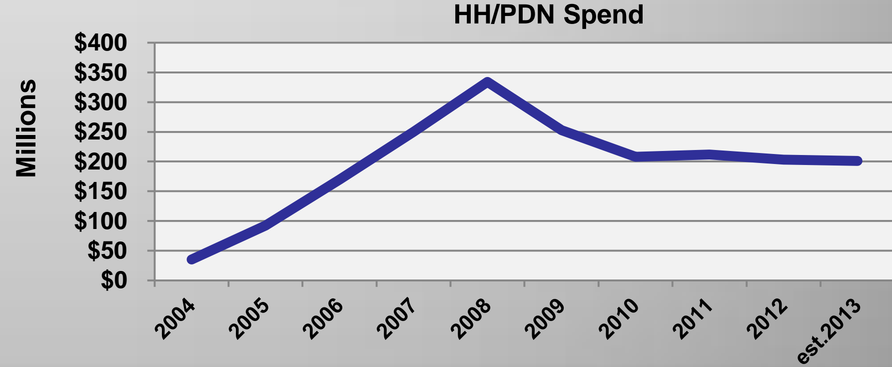
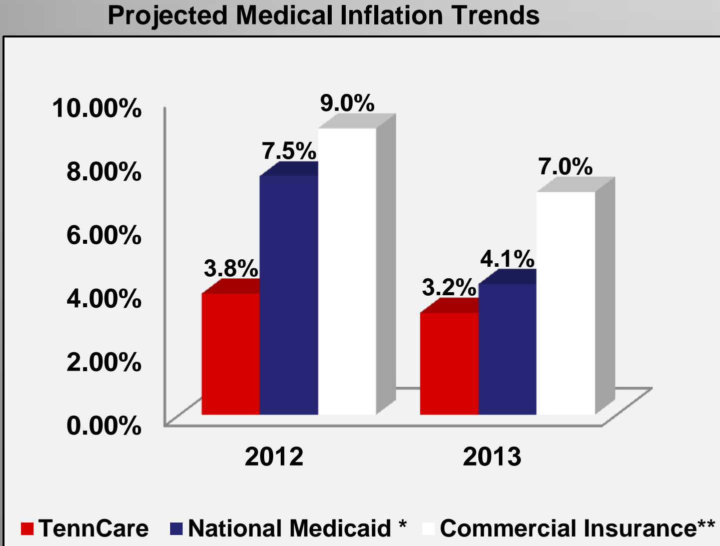
TennCare - Bending the Trend







Projected Medical Inflation Trends



*Source: OMB 2012; Kaiser 2013 **Source: PricewaterhouseCoopers

Examples of tools to control trend…

Pharmacy
- Point of Sale Edits
- Preferred Drug List/Drug Rebates/Generics
- Prescription Limits

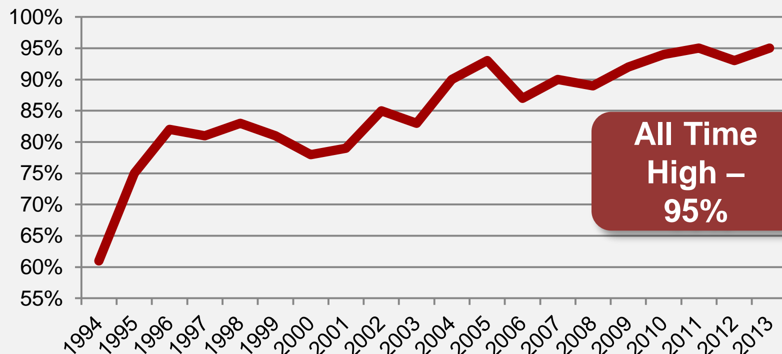
Medical
- Prior authorization
- Medical Home
- Network Consolidation
- Disease Management
- Case Management

Fraud and Abuse
- Narcotic Controls
- Pharmacy Lock-In
- Outlier Monitoring

TennCare – Quality Improvement

Background

- In 2006, TennCare became the first state in the country to require NCQA accreditation across 100% of its fully Medicaid managed care network.
- NCQA is an independent, nonprofit organization that assesses and scores managed care organization performance in the areas of quality improvement, utilization management, provider credentialing and member rights and responsibilities.
- TennCare MCOs are also required to report the full set of HEDIS measures. HEDIS is a set of standardized performance measures that makes it possible to track and compare MCO performance over time.



UT surveys random sampling of TennCare households for annual satisfaction report.

Data - HEDIS

Table 2-5a. HEDIS 2012 Plan-Specific Rates: Effectiveness of Care Measures

Measure	Amerigroup	BlueCare		TennCare Select	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Diuretics	88.08%	91.75%	91.22%	92.63%	91.83%	89.78%	89.39%	85.8%
Anticonvulsants	74.17%	77.70%	72.46%	74.64%	77.22%	73.72%	72.47%	68.6%
Total	**86.57%**	**89.97%**	**89.37%**	**78.60%**	**90.26%**	**87.93%**	**88.18%**	**84.2%**
Measures Collected Through CAHPS Health Plan Survey								
Medical Assistance With Smoking and Tobacco UseCessation (MSC)**								
Advising Smokers and Tobacco Users to Quit	78.55%	79.34%	66.67%	64.04%	74.80%	75.79%	65.67%	74.82%
Discussing Cessation Medications	43.15%	40.93%	33.98%	35.71%	41.86%	39.07%	37.21%	42.71%
Discussing Cessation Strategies	33.73%	43.44%	41.11%	46.43%	29.65%	33.82%	31.00%	38.14%

*For ASM age stratification changed for 2012 HEDIS; hence, there are no National data.

The 2012 HEDIS results showed:

Improvement in 88% of measures tracked since 2006.

Improvement in 31 of 41 measures introduced more recently.

TennCare's health plans continue to be ranked among the top 100 Medicaid health plans in the country, with our highest ranking plan moving from 37th in 2011 to 30th.

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Baseline Data Results

Baseline 2010
Program years 2011 and 2012
(2013 incomplete)

- # of HCBS participants at a point in time (CHOICES implementation for the baseline and the end of each program year thereafter) *more than doubled* (from 4,861 to 10,482 as of June 30, 2012); 12,559 as of June 30, 2013
- # of NF residents at a point in time *decreased* by more than 9% (from 23,076 at implementation to 20,968 as of June 30, 2012); 19,415 as of June 30, 2013
- Unduplicated HCBS participants across a 12-month period *more than doubled* (from 6,226 during the year prior to CHOICES to 12,862 during the program year ending June 30, 2012)
- % of NF eligible people entering LTSS choosing HCBS increased from 18.66% prior to CHOICES to 37.46% during the first 2 years of the program
- 37-day reduction in average NF length of stay
- 129 NF-to-community transitions prior to CHOICES compared to 567 and 740 in program years 1 and 2

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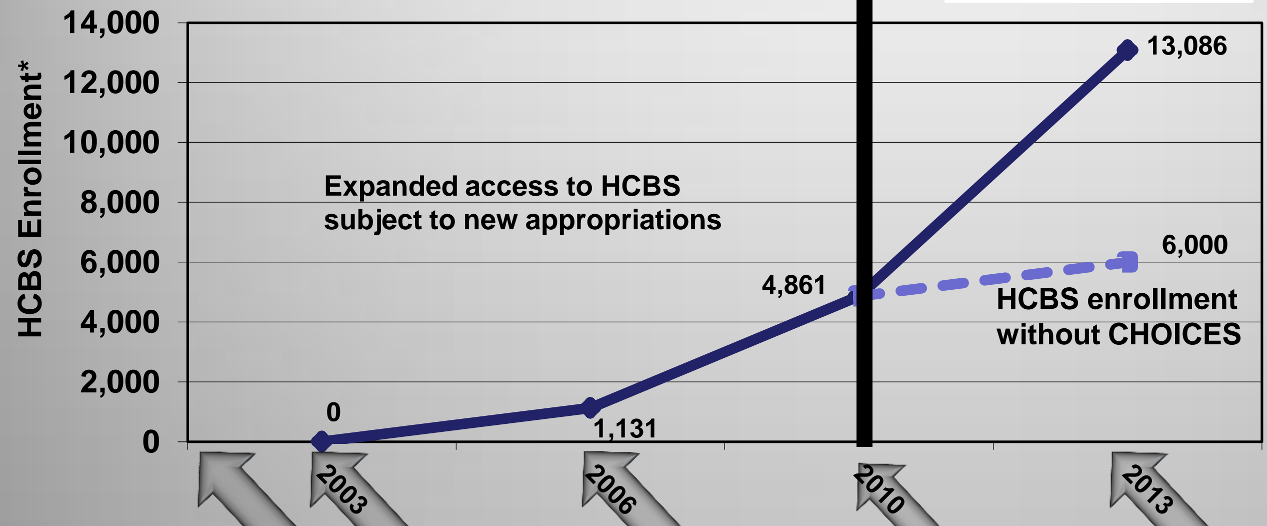
Access to Home and Community Based Services before and after



- **Global budget approach:**
  - Limited LTC funding spent based on needs and preferences of those who need care
  - More cost-effective HCBS serves more people with existing LTC funds
  - Critical as population ages and demand for LTC increases

No state-wide HCBS alternative to NFs available before 2003.

CMS approves HCBS waiver and enrollment begins in 2004.

Slow growth in HCBS – enrollment reaches 1,131 after two years.

HCBS enrollment at CHOICES implementation

Well over twice as many people who qualify for nursing facility care receive cost-effective HCBS without a program expansion request; additional cost of NF services if HCBS not available approx. $250 million (federal and state).

* Excludes the PACE program which serves 325 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.

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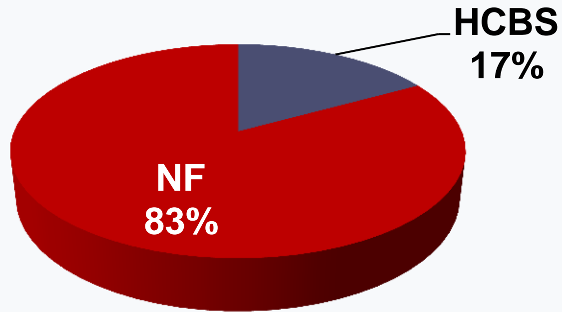
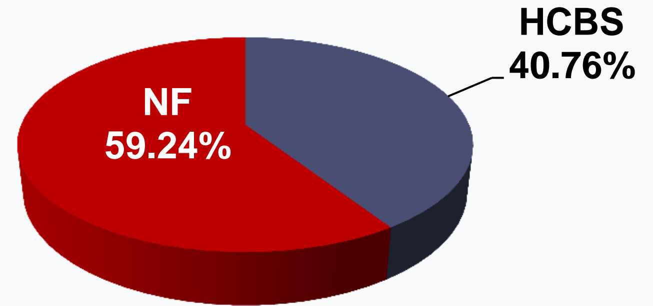
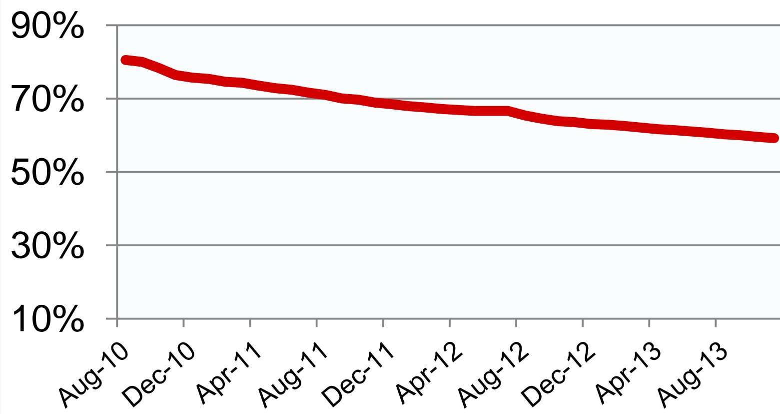
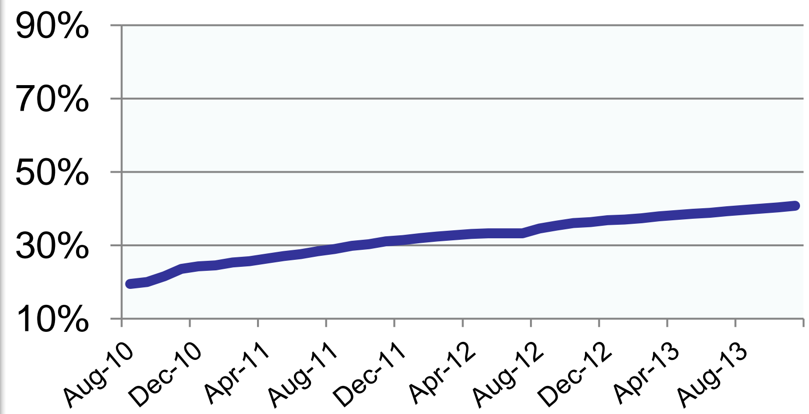
Re-Balancing LTSS Enrollment through the CHOICES Program









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Other Successes

- 96.04% of all in-home services scheduled over the last year were provided; of those visits that did not occur as scheduled, the majority (60.5%) were initiated by the member (not the provider); back-up plans required in either case
- 99.69% of all scheduled in-home services provided over the last year were on time

Continued Challenges

- NF reimbursement methodology must reflect higher acuity of NF residents and incent quality (the member's experience of care)
- Easier to rebalance enrollment than expenditures, particularly if using cost-based NF reimbursement methodology
- Misalignment of Medicare benefits continues to drive Medicaid institutional care

TennCare

Planning and Implementation Timeline

- LTC CCA
  - May 20, 2008 – Passed by the Tennessee General Assembly
  - June 17, 2008 – Signed into law
- CMS Approval
  - July 11, 2008 – CHOICES Concept Paper submitted to CMS
  - August 29, 2008 - Draft 1115 Waiver Amendment released for 30-day public comment period
  - October 2, 2008 – Formal submission of final 1115 Waiver Amendment to CMS
  - July 22, 2009 – CMS Terms and Conditions for Approval of 1115 Waiver Amendment
- MCO Contract Amendments
  - June 26, 2009 – CHOICES CRA Amendment submitted to Fiscal Review and LTC Oversight Committees
  - August 4, 2009 - Fiscal Review approved CHOICES CRA Amendment

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Planning and Implementation

- Other Key Successor/Dependent Tasks
  - Fiscal/Employer Agent contracts for Consumer Direction
  - MCO contracts with Electronic Visit Verification vendor
  - MCO staff recruitment/training
  - MCO network development
  - TDCI provider agreement template approval
  - HCBS/NF provider education materials/training
  - CHOICES rules, policies/processes, training
  - IT systems construction/configuration and testing (internal and external)—including eligibility, enrollment, and encounter processing
  - Desk Readiness Assessments-policy/process deliverables
  - On-site Readiness Assessments of IT systems and operations
  - Member education materials/notices
- Phased Implementation
  - Middle Region – March 2010
  - East/West Region – August 2010

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Takeaways and Advice

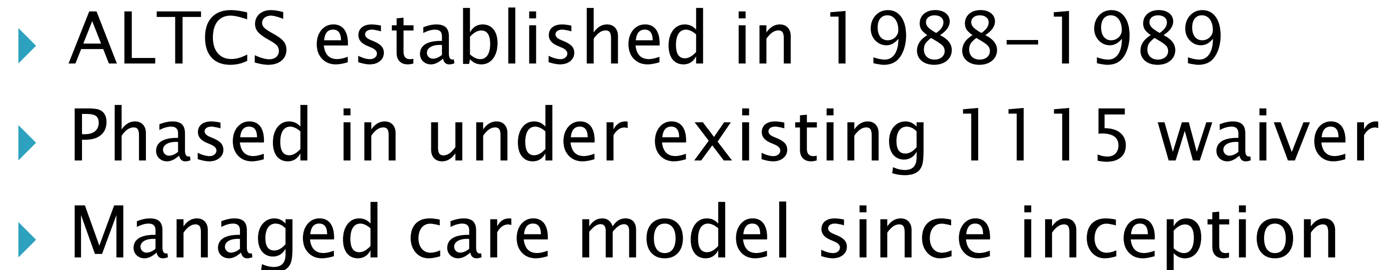
- Managed care is a set of tools and principles that can help improve coordination, quality and cost-effectiveness of care for the most complex populations. It is up to us to implement those tools in the right way to achieve the desired objectives and preserve core system values.
- Implementing managed care "well" and achieving program objectives requires a significant investment in the State's capacity to manage managed care.
- It takes time to design and implemented managed care. Moving too quickly will undermine the success of your program.
- While managed care has significant potential for cost containment and even savings, assuming too much too soon will result in unintended negative consequences, and will undermine quality and cost effectiveness goals.
- Be careful not to confuse the success of the model with the success of the implementation.

TENNCARE

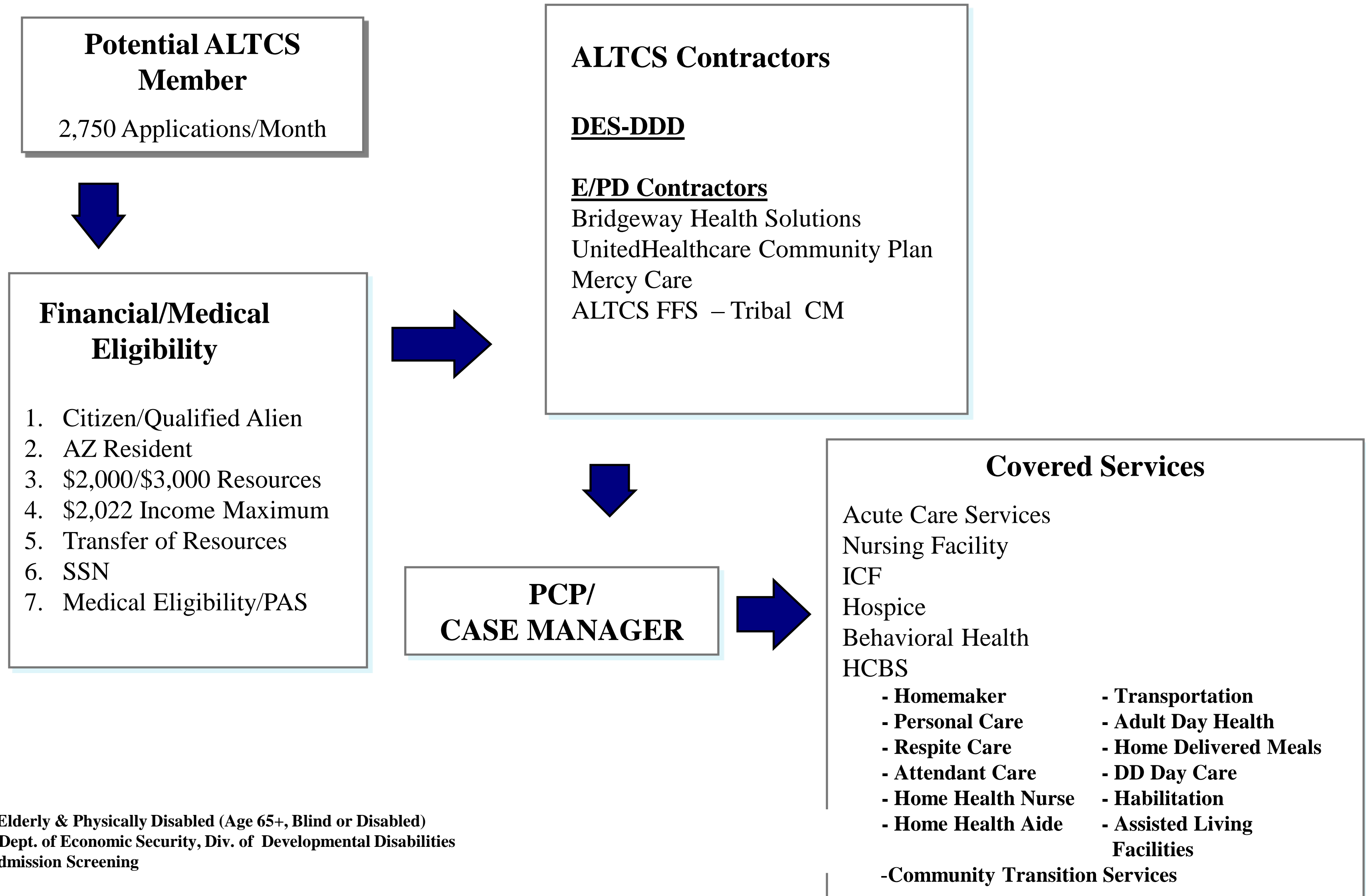
State Oversight and Quality in Managed Long Term Services and Supports

Friday Morning Collaborative
December 6, 2013

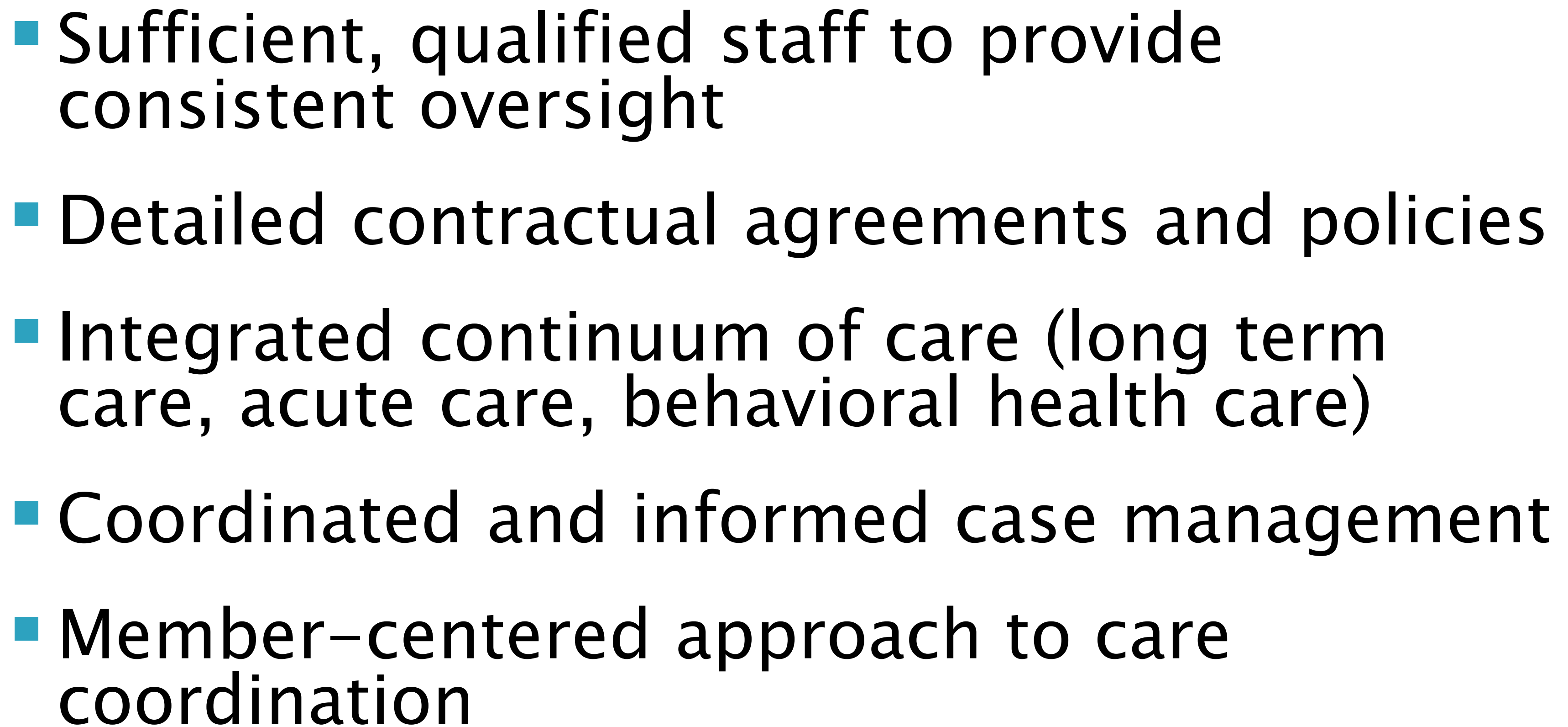
Arizona Long Term Care System (ALTCS)



ALTCS System Design

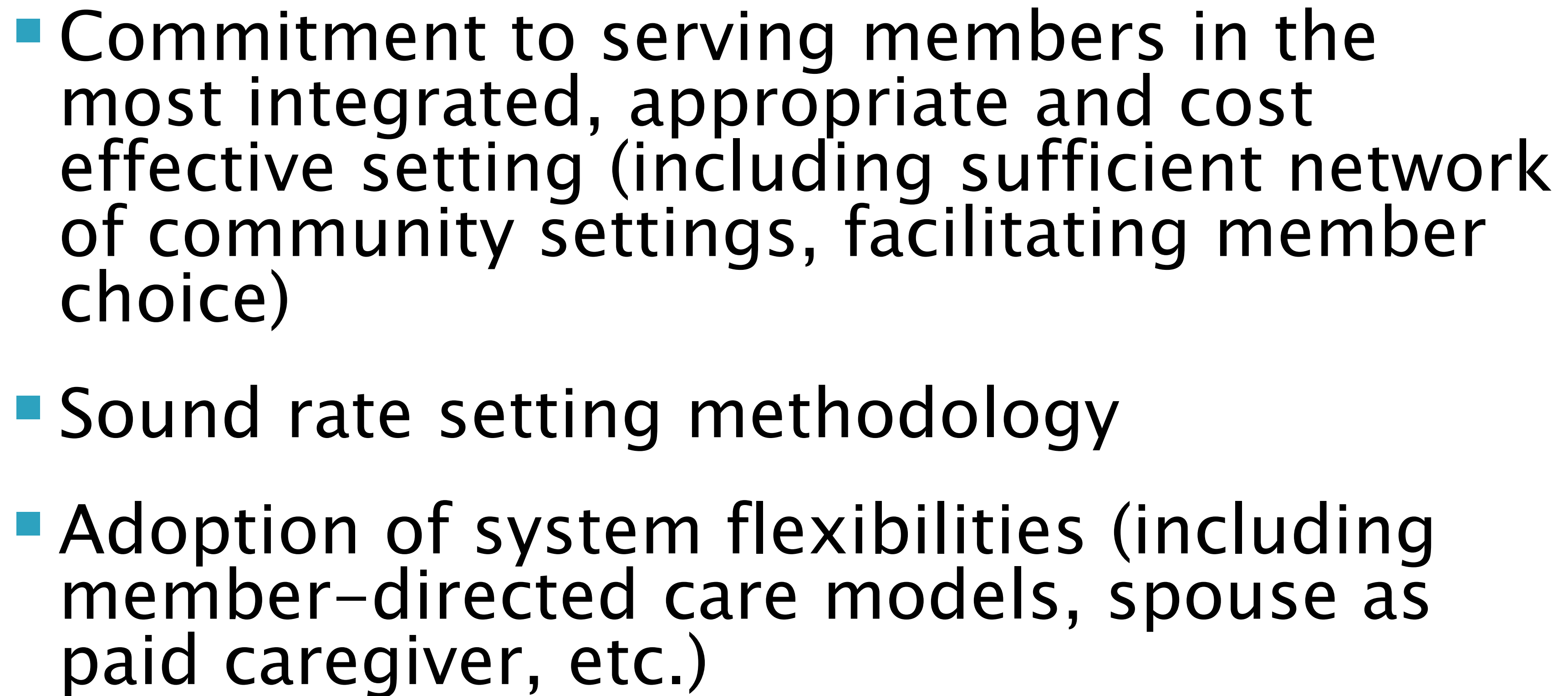


Key Considerations in Building a Managed LTSS Program

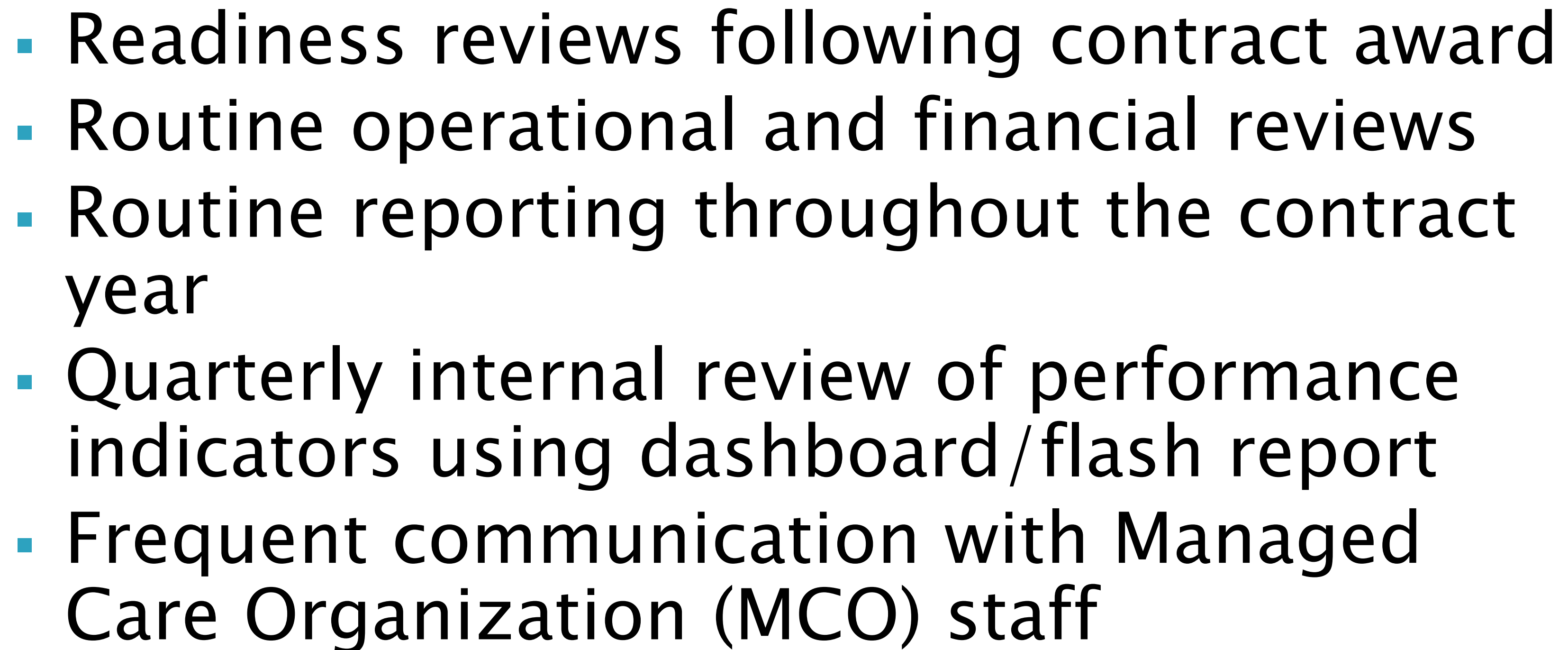


- Sufficient, qualified staff to provide consistent oversight
- Detailed contractual agreements and policies
- Integrated continuum of care (long term care, acute care, behavioral health care)
- Coordinated and informed case management
- Member-centered approach to care coordination

Key Considerations in Building a Managed LTSS Program



Oversight Tools Used to Measure Quality in a Managed LTSS Program

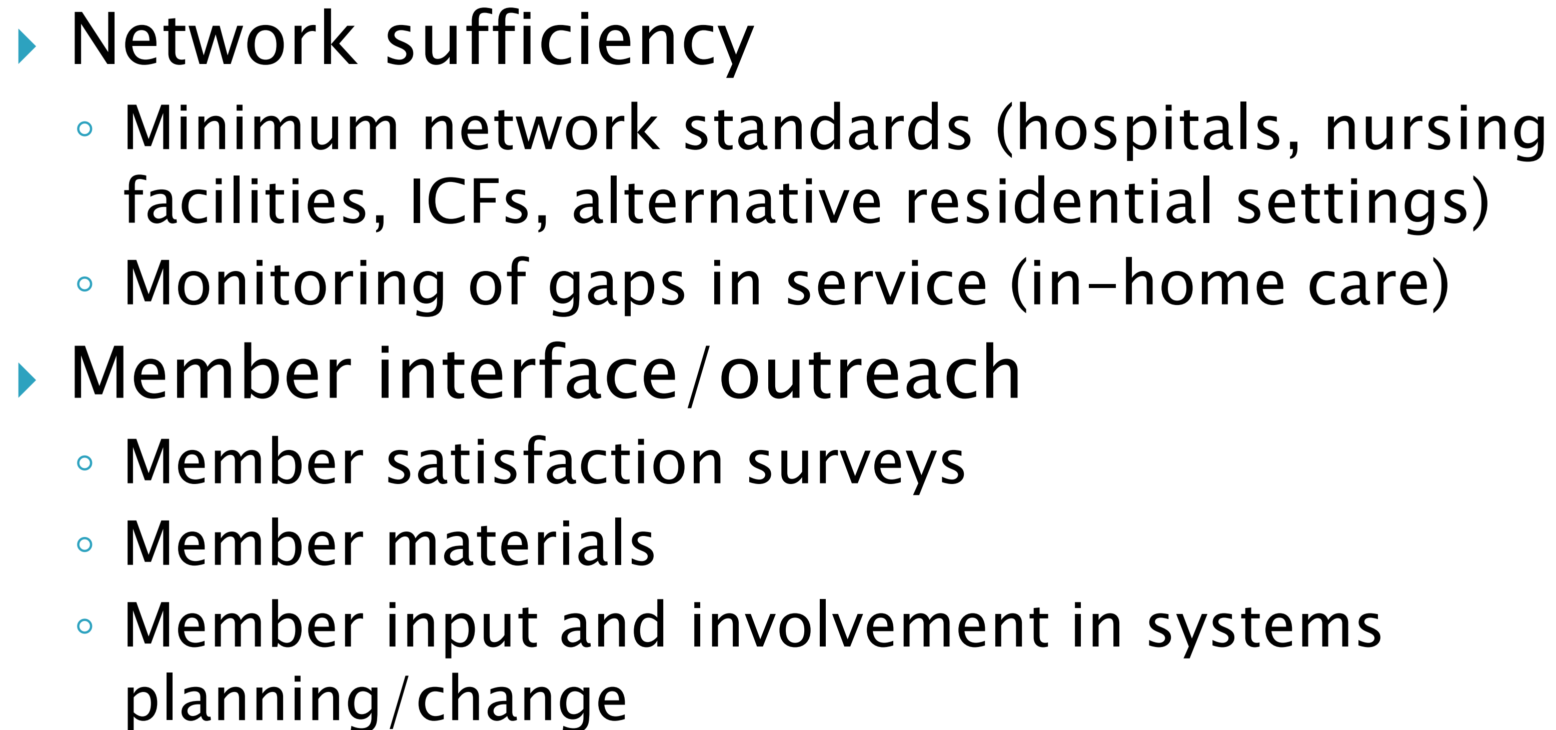


- Readiness reviews following contract award
- Routine operational and financial reviews
- Routine reporting throughout the contract year
- Quarterly internal review of performance indicators using dashboard/flash report
- Frequent communication with Managed Care Organization (MCO) staff

Indicators Used to Gauge Quality in a Managed LTSS Program

- Quality management
  - Performance measures
  - Performance improvement projects
  - Quality of care concerns
- Case management
  - Standardization of service planning process (person-centered, strengths based)
  - Timelines for initial contact, reassessment
  - Established case load ratios
- Operational measures
  - Claims payment
  - Encounter submission

Indicators Used to Gauge Quality in a Managed LTSS Program



Questions

For More Information:

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External Quality Review: An Overview and New Guidance on MLTSS

Center for Medicaid and CHIP Services

TJ Shumard, MPH
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Division of Quality, Evaluation & Health Outcomes

December 6, 2013

Intro to Managed Care Quality

- Regulations were passed in response to the Balanced Budget Act of 1997, which set forth new quality standards for Medicaid managed care
- Regulatory requirements:
  - 42 CFR Part 438, subpart E requires states contracting with certain managed care entities to participate in an external quality review (EQR) process, which consists of 3 mandatory and 5 optional activities

EQR Definitions

- External quality review (EQR) means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid beneficiaries.
  - MCO = Managed Care Organization
  - PIHP = Prepaid Inpatient Health Plan
- An External Quality Review Organization (EQRO) is an organization that meets the competence and independence requirements set forth in CMS regulation, and performs EQR and other EQR-related activities.

Current EQROs

- 41 States are required to utilize EQR
  - Including the District of Columbia and Puerto Rico

- **Acumentra**
- **APS Healthcare**
- **Behavioral Health Concepts (BHC)**
- **Burns & Associates**
- **Delmarva Foundation for Medical Care**
- **HCE QualityQuest (QQ)**
- **Health Services Advisory Group (HSAG)**
- **HealthInsight New Mexico**
- **Institute for Child Health Policy (ICHP)**
- **IPRO**
- **Kansas Foundation for Medical Care**
- **Mercer**
- **MetaStar, Inc.**
- **MPRO**
- **QSOURCE**
- **Telligen**
- **The Carolinas Center for Medical Excellence**

What are the mandatory EQR activities?

- 3 mandatory activities
  - Validation of Performance Measurements (annual)
  - Validation of Performance Improvement Projects (annual)
  - A review to determine health plan compliance with standards related to access, operations, and quality measurement and improvement (at least once every three years)

The optional activities of EQR

- 5 optional activities
  - Validation of Encounter Data
  - Administration or validation of consumer or provider surveys
  - Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO
  - Conduct of performance improvement projects in addition to those conducted by an MCO or PIHP
  - Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

EQR Technical Report

- Annual deliverable that must include information on:
  - Data from all EQR activities conducted, aggregated and analyzed
  - Conclusions drawn for quality, timeliness, and access to the care furnished by each MCO or PIHP
- CMS abstracts data from these reports for the annual Department of Health and Human Services (DHHS) Secretary's report on Medicaid & CHIP quality of care
  - http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf
- Currently available state EQR technical reports are posted at:
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html

CMS EQR Protocols

- § 438.352 External quality review protocols. Each protocol must specify—
  (a) The data to be gathered;
  (b) The sources of the data;
  (c) The activities and steps to be followed in collecting the data to promote its accuracy, validity, and reliability;
  (d) The proposed method or methods for validly analyzing and interpreting the data once obtained; and
  (e) Instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol
- What is the purpose of the protocols?
  – Promote consistency in reporting from state to state
  – Ensure that data collection, validation and reporting is consistent with regulations and CMS expectations

New MLTSS EQR Guidance

- New guidance offers specific suggestions to apply the existing EQR Protocols to long term services and supports (LTSS).
  - Guidance is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html

General guidance on application of EQR protocols to MLTSS

- Providers and Provider Types
  - States should consider including nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and community based LTSS providers
- Services
  - States should consider including non-traditional medical type services that assist in:
    - activities of daily living (e.g., eating, dressing)
    - instrumental activities of daily living codes (e.g., taking medications)
    - living independently

New Guidance on Mandatory EQR Activities: Protocol 1

- Assessment of Compliance with Regulations

• Review LTSS providers by type within network • Physical accessibility of service sites and medical/diagnostic equipment • Availability and use of HCBS as alternatives to institutional care • Credentialing or other selection process for LTSS providers	• Person-centered assessment, service coordination and care management for LTSS • Integration of managed medical, behavioral and LTSS

New Guidance on Mandatory EQR activities: Protocol 2

- Validation of Performance Measures

• Assess the Integrity of the MCO's Information for capturing LTSS claims/encounter data • For example, states should consider LTSS such as personal care, equipment and supplies, transportation, home modifications, supported employment, when evaluating the accuracy and completeness of data used to measure each service.	• Review Information Systems for capturing LTSS claims/encounter • For example, states should consider case management systems and other data systems that capture information from beneficiary care plans

New Guidance on Mandatory EQR Activities: Protocol 3

- Validating Performance Improvement Projects (PIPs)

- **States should include, where applicable, PIPs on for adults with physical disabilities, people with intellectual and developmental disabilities**
- **States should consider avoidable hospitalizations or ED visits, which can serve as indicators of care coordination.**
- **States that use electronic visit verification systems (EVV) for LTSS should consider those systems as a potential data source**
- **States, when using the PIP Review Worksheet, should add “managed LTSS plan” to the list of delivery systems.**

New Guidance on Optional EQR Activities: Protocols 4-8

- **Protocol 4: Validation of Encounter Data**
  - **States should establish standards for encounter data reporting for home and community-based LTSS**
- **Protocol 5: Surveys**
  - **For some population subgroups such as people with intellectual and developmental disabilities, or with cognitive impairments, personal interviews may be the only effective survey approach**
- **Protocol 6: Calculation of Performance Measures**
  - **States should consider the medical record as inclusive of individual health and other LTSS**
- **Protocol 7: Implementation of PIPs**
  - **States should consider adding case management systems, EVV systems, and other LTSS data systems as information sources**
- **Protocol 8: Focused Studies**
  - **Useful to states that wish to conduct studies focusing on LTSS**

Additional Resources

- A series of technical assistance documents related to EQR are available at:
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

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Thank You

Questions

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